DATE: _____ LICENSE NAME: _____

FACILITY NAME: _____ ADDRESS: _____

FACILITY TYPE: AFC CORPORATE: _____
ADULT FAMILY: _____
CHILD LICENSE: _____
AGE VARIANCE: _____

STAFFING: AM HOURS _____ # OF STAFF _____
PM HOURS _____ _____
NIGHT HRS _____ _____(AWAKE)
_____(ASLEEP)

CONTACT PERSON: _____ EMAIL: _____

PHONE: _____ FAX: _____

RETURN COMPLETED FORM TO: "YOUR" AFC LICENSOR,
ST. LOUIS CTY. , 320 W 2ND ST, ROOM 503, DULUTH MN 55802

MA / UMPI # _____

DATE PLACED	DATE DIS-CHARGED & WHERE	CLIENT NAME & DATE OF BIRTH	COUNTY OF FINANCIAL RESP. AND CURRENT CASE MANAGER/ SOCIAL WKR, NAME, PHONE #, AND ADDRESS **And** FINANCIAL WKR	WAIVER TYPE & PER- DIEM PAYMENT	DAY PROG OR SUPPORTIVE EMPLOYMENT, ARMS; please identify which services recd.	HOURS/ UNITS
		Last name: DOB First name: PMI Number:	SW: FW:			
		Last name: DOB First name: PMI Number:	SW: FW:			
		Last name: DOB First name: PMI Number:	SW: FW:			
		Last name: DOB First name: PMI Number:	SW: FW:			
		Last name: DOB First name: PMI Number:	SW: FW:			

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